

To:

County Birth to 3
Programs

Home Health
Agencies

Occupational
Therapists

Outpatient
Hospital
Providers

Physical
Therapists

Rehabilitation
Agencies

Speech and
Hearing Clinics

Speech-Language
Pathologists

Therapy Groups

HMOs and Other
Managed Care
Programs

Elimination of need for renewal of prior authorization requests for therapy services provided as part of the Birth to 3 Program

Effective for prior authorizations (PAs) granted on and after July 1, 2002, Wisconsin Medicaid has a new process which eliminates the need for renewal of PA requests for occupational therapy (OT), physical therapy (PT), and speech and language pathology (SLP) services provided to Medicaid-eligible children as part of the Birth to 3 (B-3) Program per HFS 90, Wis. Admin. Code.

Simplified prior authorization process at a glance

Effective July 1, 2002, Wisconsin Medicaid will:

- Require therapy providers to submit a prior authorization (PA) request *only once* per child, per therapy type, per provider for therapy groups and for independent therapy providers.
- Require rehabilitation agencies to submit a PA request *only once* per child per therapy type.
- Grant PA up to the recipient's third birthday.

The only children to whom the new B-3 process applies meet one of the following criteria:

- Receive an initial evaluation and assessment for the Birth to 3 (B-3) Program.
- Participate in the B-3 Program.

This process is effective for PAs granted on and after July 1, 2002.

Details of new prior authorization process

To qualify for submission of PA forms under the new process, all services must be provided by Wisconsin Medicaid-certified therapists who are employed by, or under agreement with, a B-3 agency to provide B-3 services. To qualify for the new process, the therapy services must be prescribed by a physician and be one or both of the following:

- Provided in conjunction with the B-3 initial evaluation and assessment in accordance with HFS 90, Wis. Admin. Code, even if the evaluation and assessment determines the child is not eligible for B-3 services.

- Identified in the recipient's Individualized Family Service Plan (IFSP) and performed at the same frequency, intensity, and duration listed in the IFSP. Wisconsin Medicaid will not reimburse beyond the frequency and duration specified in the prescription or the physician-signed plan of care.

New process steps

Wisconsin Medicaid has created a new Prior Authorization/Birth to 3 Therapy Attachment (PA/B3). The provider may choose to use this form in either of the following situations:

- Two to four weeks before the child's initial 35 treatment days per discipline per spell of illness have been used.
- At any time once a therapy evaluation or service has been initiated through the B-3 Program.

To receive authorization, a provider must use this form and follow the steps below:

- *Step 1:* Read and complete the Prior Authorization Request Form (PA/RF). Providers do not need to specifically list procedure codes on the PA/RF. Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for completion instructions and a sample PA/RF.
- *Step 2:* Read and complete the PA/B3 and attach it to the PA/RF. Refer to Attachment 3 for a copy of the new PA/B3 and completion instructions.
- *Step 3:* Submit only the completed PA/RF and PA/B3 to Wisconsin Medicaid.

- *Step 4:* The signature and credentials of the provider performing the service must appear on the PA/RF. In the blank space to the right of the signature, indicate the start date for which the services are being requested if other than the date received by Wisconsin Medicaid. Current Medicaid policy allows backdating up to two weeks for new therapy PA requests and does not allow backdating for ongoing therapy requests.

Once Wisconsin Medicaid receives and grants approval of the PA/RF and PA/B3, providers may submit claims for the procedure codes listed in Attachment 4 for each respective therapy type.

Obtaining the Prior Authorization/Birth to 3 Therapy Attachment

Providers may obtain the PA/B3 through any of the following options:

- Photocopy the PA/B3 included in Attachment 3.
- Download a fillable Portable Document Format (PDF) version from the Wisconsin Medicaid Web site at www.dhfs.state.wi.us/medicaid/.
- Have a printable PDF version sent to their e-mail address.
- Write to the Wisconsin Medicaid Form Reorder Unit at:
Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Obtaining the Portable Document Format copy on the Web

The fillable PDF version allows providers to complete the PA/B3 on their computers using Adobe Acrobat Reader® and then print it. To obtain the fillable PDF, follow these steps:

- Go to the Medicaid Web site at www.dhfs.state.wi.us/medicaid/.
- Click on “Providers.”
- Under “Provider Publications and Forms,” select “Provider Updates By Date.”
- Select this *Update* (2002-33) by choosing “2002” under “Search for Updates by year” and finding “2002-33.” Providers may also find the *Update* under “Provider Updates By Provider Type.”
- Select Attachment 3 within the text of the *Update* and save it to your computer.
- Click on the dash-outlined boxes with the hand tool to enter information in each field. Press the “tab” key to get to each field.

Obtaining a Portable Document Format copy via e-mail

Providers with e-mail may receive the order form in PDF via e-mail, even if they do not have Internet access. Providers who wish to use this option may send an e-mail to the following address: 2002-33@wimedicaid.org. This e-mail should not include any text (e.g., policy questions, requests for materials, claims status inquiries), as the response containing the PDF file is generated automatically and will not contain answers to questions or fulfill requests for other information.

Providers will receive a reply, via e-mail, containing the PDF *Update* and form within one business day of the request. The PDF form may then be printed or shared electronically with others.

Situations that do not meet the criteria for the new prior authorization process

For situations that do not meet the criteria for the new PA process, providers must follow Wisconsin Medicaid’s current PA process.

The new PA B-3 process and PA/B3 may not be used for any of the following:

- Children not participating in the B-3 Program or who are not being evaluated as part of the initial B-3 assessment.
- Services provided by Wisconsin Medicaid therapists who are not employed by or under agreement with a B-3 agency to provide B-3 services.
- Services not identified in the IFSP.
- Procedure codes not listed in Attachment 4.
- Co-treatment services.

A Prior Authorization/Therapy Attachment (PA/TA) or Prior Authorization/Spell of Illness Attachment (PA/SOIA) must be submitted for any of the above situations. Refer to Attachment 5 for guidelines on choosing the correct PA attachment form. Refer to the appropriate service-specific handbook for information on current PA requirements for each provider type.

Existing prior authorization for services meeting the criteria for the new process

Any current, approved PA for a B-3 recipient remains in effect until its expiration date. Providers should not submit the new PA/B3 or use the new process until two to four weeks before the current PA expiration date. Wisconsin Medicaid will not amend current PAs to reflect the new process. Refer to Attachment 5 for guidelines on appropriate and inappropriate situations in which to use the new PA process.

Changes in billing providers during treatment

In some cases, a recipient may change billing providers during treatment but still have a PA on file with Wisconsin Medicaid that is authorized to the recipient's previous billing provider.

In situations where there is a change in billing providers during treatment, the new billing provider should submit the following items to Wisconsin Medicaid:

- A new PA/RF.
- A new PA/B3.
- A letter **signed**, if possible, by the previous *billing* provider or recipient, requesting the current PA be end-dated prior to the effective date of the new PA.

For more information on changes in billing providers and PA, refer to the All-Provider Handbook.

Individualized Family Service Plan does not establish medical necessity

In accordance with HFS 90, Wis. Admin. Code, the IFSP describes the outcomes, strategies, supports, and services appropriate to meet the child's and family's needs. The IFSP does *not* establish medical necessity.

All services billed to Wisconsin Medicaid must meet Wisconsin Medicaid's standards of medical necessity, as well as all other Medicaid requirements for reimbursement as specified in HFS 101-108, Wis. Admin Code. Wisconsin Medicaid may recoup reimbursement for any service that does not meet these requirements.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.

ATTACHMENT 1

Prior Authorization/Request Form (PA/RF) completion instructions to be submitted with the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

Element 1 — Processing Type

Enter the appropriate three-digit processing type from the list below. The “processing type” is a three-digit code used to identify a category of service requested.

160 — Physical Therapy

161 — Occupational Therapy

162 — Speech and Language Pathology

Element 2 — Recipient’s Medical Assistance ID Number

Enter the recipient’s 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient’s Name

Enter the recipient’s last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient’s name. If the name or spelling of the name on the Medicaid Forward card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient’s place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient’s date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex

Enter an “X” to specify whether the recipient is male or female.

Element 7 — Billing Provider’s Name, Address, ZIP Code

Enter the billing provider’s name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

Enter the billing provider’s telephone number, including the area code of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.

Enter the billing provider’s eight-digit Medicaid provider number.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary

Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code (not required)

Element 15 — MOD

Enter the modifier corresponding to the type of therapy listed below:

| Therapy Type | Modifier |
|-------------------------------|------------------------------------|
| Occupational Therapy | OT |
| Physical Therapy | PT |
| Speech and Language Pathology | Leave blank — no modifier required |

Element 16 — POS

Enter the number of the place of service in which therapy will *usually* be provided:

| Code | Description |
|------|-------------|
| 0 | Other |
| 3 | Clinic |
| 4 | Home |

Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code:

| Alpha | Description |
|-------|--------------------------|
| 1 | All other provider types |
| 9 | Rehabilitation agency |

Element 18 — Description of Service

Enter “Birth to 3” and the type of therapy services (e.g., “Birth to 3 OT services” for occupational therapy services).

Element 19 — QR (not required)**Element 20 — Charges (not required)****Element 21 — Total Charge (not required)****Element 22 — Billing Claim Payment Clarification Statement**

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient’s and provider’s eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the Prior Authorization Request Form (PA/RF) was completed and signed.

Element 24 — Requesting Provider Signature

The signature and credentials of the provider performing the service must appear in this element. In the blank space to the right of Element 24, please indicate the start date for which services are being requested.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.

ATTACHMENT 2

Sample Prior Authorization/Request Form (PA/RF) to be submitted with the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

| | | | | | | | | | | | |
|---|--|--|--|---|---|--------------------------|--|--|--|--|--|
| MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088 | | | | PRIOR AUTHORIZATION REQUEST FORM <div style="border: 1px solid black; display: inline-block; padding: 2px;">PA/RF</div> (DO NOT WRITE IN THIS SPACE) ICN # A.T. # P.A. # 1234567 | | | | 1 PROCESSING TYPE <div style="border: 1px solid black; display: inline-block; padding: 10px 20px;">161</div> | | | |
| 2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890 | | | | 4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow St. Anytown, WI 55555 | | | | | | | |
| 3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Ima | | | | 8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX | | | | | | | |
| 5 DATE OF BIRTH MM/DD/YYYY | | | 6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> | | 9 BILLING PROVIDER NO. 87654300 | | | | | | |
| 7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Billing 1 W. Williams Anytown, WI 55555 | | | | 10 DX: PRIMARY 783.4 Developmental delays | | | | | | | |
| | | | | 11 DX: SECONDARY | | | | | | | |
| | | | | 12 START DATE OF SOI: | | 13 FIRST DATE RX: | | | | | |

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|-------------------|--------|--------|--------|---------------------------|--------------|------------|
| | OT | 4 | 1 | Birth to 3 OT services | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGE | 21 |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

| | | |
|---|---|-------------------------------|
| 23 <u>MM/DD/YYYY</u> <small>DATE</small> | 24 <u>I.M. Provider</u> <small>REQUESTING PROVIDER SIGNATURE</small> | Start Date: <u>MM/DD/YYYY</u> |
|---|---|-------------------------------|

(DO NOT WRITE IN THIS SPACE)

| | | | | | |
|---|---------|--|---|--------------------------------|----------------------------|
| AUTHORIZATION: <input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED <input type="checkbox"/> DENIED <input type="checkbox"/> RETURN | REASON: | <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> <small>GRANT DATE</small> | <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> <small>EXPIRATION DATE</small> | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED |
|---|---------|--|---|--------------------------------|----------------------------|

DO NOT write in this space.

Reserved for Medicaid use.

| | |
|------|------------------------------|
| DATE | CONSULTANT/ANALYST SIGNATURE |
|------|------------------------------|

ATTACHMENT 3

Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)

(A copy of the Prior Authorization/Birth to 3 Therapy Attachment
[PA/B3] is located on the reverse side of this page.)



WISCONSIN MEDICAID

PRIOR AUTHORIZATION / BIRTH TO 3 THERAPY ATTACHMENT (PA/B3)

The Wisconsin Medicaid program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

REMINDER TO PROVIDERS

Providers are reminded that all services must meet the rules and regulations of Wisconsin Medicaid as found in HFS 101-108, Wis. Admin. Code. Providers are further reminded that prior authorization (PA) does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Attach this form to the Prior Authorization Request Form (PA/RF). Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers may also mail requests to Wisconsin Medicaid at:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

| | |
|--|---|
| Name — Recipient (Last, First, Middle Initial) | Recipient Medicaid Identification Number |
| Name — Therapist (Last, First, Middle Initial) | Therapist or Rehabilitation Agency Medicaid Provider Number |

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the recipient's eligibility for the Birth to 3 Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the recipient.

OR

- I am providing ongoing therapy services and I certify that all of the following are true:
 - ✓ The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
 - ✓ The therapy services I am providing to the recipient named above are as stated in the child's current and valid IFSP.
 - ✓ The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the recipient's IFSP.
 - ✓ The recipient of the services is enrolled in a Birth to 3 (B-3) Program for all dates of service and is younger than three years of age.
 - ✓ I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
 - ✓ The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and *Wisconsin Medicaid and BadgerCare Updates*.
 - ✓ I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

| | |
|------------------------------|--------------------------|
| SIGNATURE — Therapist | Date Signed (MM/DD/YYYY) |
|------------------------------|--------------------------|

ATTACHMENT 4

List of procedure codes that may be billed under the new prior authorization process

The following chart lists *Current Procedural Terminology* (CPT) codes that may be performed. Providers requesting prior authorization (PA) for codes that are not included below are required to request PA using Wisconsin Medicaid's current policies and procedures. Providers may use any of these as appropriate to the Individualized Family Service Plan (IFSP). Wisconsin Medicaid does not reimburse beyond the frequency, intensity, and duration of services listed in the IFSP, prescription, or physician-signed plan of care, whichever indicates the least amount of services.

| Physical Therapy CPT Codes and Descriptions | |
|--|---|
| CPT Code | Description |
| 97001 | Physical therapy evaluation |
| 97002 | Physical therapy re-evaluation |
| 97110 | Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| 97112 | Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities |
| 97113 | Aquatic therapy with therapeutic exercises |
| 97116 | Gait training (includes stair climbing) |
| 97140 | Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes |
| 97530 | Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes |
| 97535 | Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by the provider, each 15 minutes |

| Occupational Therapy CPT Codes and Descriptions | |
|--|---|
| CPT Code | Description |
| 97003 | Occupational therapy evaluation |
| 97004 | Occupational therapy re-evaluation |
| 97110 | Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| 97112 | neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities |
| 97140 | Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes |
| 97150 | Therapeutic procedure(s), group (2 or more individuals) (Report 97150 for each member of the group) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist) |
| 97530 | Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes |
| 97532 | Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes |
| 97535 | Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by the provider, each 15 minutes |

| Speech and Language Pathology CPT Codes and Descriptions | |
|---|--|
| CPT Code | Description |
| 92506 | Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status |
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual |
| 92508* | group, two or more individuals |

*Wisconsin Medicaid limits groups to two to four individuals.

ATTACHMENT 5

Prior authorization situational table

The chart below is a breakdown of when providers should submit the Prior Authorization/Birth to 3 Therapy (PA/B3), the Prior Authorization/Spell of Illness Attachment (PA/SOIA), or the Prior Authorization/Therapy Attachment (PA/TA). Providers should refer to their service-specific handbooks for more information on the PA/SOIA and the PA/TA.

Providers are reminded that they are always required to submit a Prior Authorization Request Form (PA/RF) regardless of the attachments they send.

| Situation | Therapy services are provided as part of the Birth to 3 (B-3) Program by B-3 agency-contracted providers Which form? | Therapy services are provided outside the B-3 Program Which form? |
|---|---|--|
| Initial B-3 eligibility evaluation/assessment. | Submit the PA/B3. | Not applicable. |
| Services in excess of 35 treatment days per spell of illness (SOI). | Submit the PA/B3. | Submit the PA/SOIA or the PA/TA. |
| Services provided during the development of a permanent or interim Individualized Family Service Plan (IFSP). | Submit the PA/B3. | Submit the PA/SOIA or the PA/TA. |
| Services (other than the initial evaluation) not included in the IFSP. (For example, if the child receives speech-language pathology [SLP] services from a non-B-3 SLP provider.) | Not applicable. | Submit the PA/SOIA or the PA/TA. |
| Services exceed the frequency established in the IFSP. (Frequency must be specific; ranges of time are not accepted. For example, "2 to 3 times per week" is not acceptable.) | Not applicable. | Submit the PA/SOIA or the PA/TA. |
| Services provided on or after the child's third birthday. | Not applicable. | Submit the PA/SOIA or the PA/TA. |
| Unlisted (nonspecific) procedure codes. | Submit the PA/SOIA or the PA/TA. | Submit the PA/SOIA or the PA/TA. |
| Co-treatment. | Submit the PA/SOIA or the PA/TA. | Submit the PA/SOIA or the PA/TA. |